No. 11-400

IN THE
Supreme Court of the United States

STATE OF FLORIDA, *et al.*,
Petitioners,
v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF RESPONDENTS WITH RESPECT TO MEDICAID

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STATEMENT OF INTEREST[1]

The American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, Federation of American Hospitals, National Association of Children's Hospitals, and National Association of Public Hospitals and Health Systems respectfully submit this brief as *amici curiae*.

The American Hospital Association represents nearly 5,000 hospitals, health care systems, and

[1] No party or counsel for a party authored or paid for this brief in whole or in part, or made a monetary contribution to fund the brief's preparation or submission. No one other than *amici* or their members or counsel made a monetary contribution to the brief. All parties filed blanket *amicus* consent letters.

networks, plus 37,000 individual members. AHA members are committed to improving the health of communities they serve and to helping ensure that care is available to, and affordable for, all Americans. The AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health care policy.

The Association of American Medical Colleges represents about 300 major non-federal teaching hospitals, all 136 accredited medical schools, and the clinical faculty and medical residents who provide care to patients there. AAMC member hospitals provide some 28 percent of the nation's Medicaid inpatient care. AAMC, *Cuts to Doctor Training Will Hurt the Nation's Health, Economy* (Sept. 19, 2011).[2]

The Catholic Health Association of the United States is the national leadership organization for the Catholic health ministry. Comprised of more than 600 hospitals and 1,400 long-term care and other health facilities in all 50 states, the Catholic health ministry is the largest group of nonprofit health care providers in the nation. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Federation of American Hospitals is the representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and Washington D.C. These members include rural and urban teaching and non-teaching hospitals and provide a wide range of acute, post-acute, and ambulatory services.

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[2] *Available at* https://www.aamc.org/download/262676/data/gmefactsheet.pdf.

The National Association of Children's Hospitals supports its 221 hospital members in addressing public policy issues. N.A.C.H.'s mission is to promote the health and well-being of children and their families through support of children's hospitals and health systems. Medicaid is the single largest insurer of children and the largest payer for children's hospitals. On average, Medicaid covers around 50 percent of the care provided by children's hospitals.

The National Association of Public Hospitals and Health Systems is comprised of some 140 of the nation's largest metropolitan safety net hospitals and health systems, committed to providing health care to all without regard to ability to pay. The majority of patients served by NAPH members are either uninsured or enrolled in Medicaid, accounting for 54 percent of all inpatient discharges and 57 percent of all outpatient visits. NAPH represents members' interests in matters before Congress, the Executive Branch, and the courts.

The six Hospital Associations represent virtually every hospital and health system in the country. They regularly participate as *amici* in cases raising issues of concern to the healthcare field, including other cases currently before this Court arising out of the Patient Protection and Affordable Care Act ("ACA"). They are participating here because healthcare providers are at the heart of federal-state cooperative health care payment programs such as Medicaid. Petitioners' "coercion" theory would threaten those programs, handcuffing Congress in its attempts to innovate and to ensure that Medicaid operates effectively for healthcare providers and

their patients. That outcome is neither wise nor compelled by the Constitution.

SUMMARY OF ARGUMENT

Petitioners argue that if a state cannot "afford to turn down" the "federal inducement" of Medicaid funding, then the Medicaid program amounts to unlawful "coercion" and the ACA's Medicaid provisions must fall. Pet. 23. It is important to understand the practical consequences of that argument for America's healthcare providers and the patients they serve. Congress has seen fit to modify Medicaid dozens of times over the decades to expand eligibility and expand or contract states' flexibility regarding coverage and provider compensation. *See infra* at 18-19. Congress enacted these and many similar modifications because it became convinced that they were necessary to keep the system running smoothly in light of changes on the ground. But if Petitioners' "coercion" theory were law, Congress could not make *any* modifications to the Medicaid program—or to any other significant cooperative federal-state program—unless *every participating state agreed to the proposed change*.

This heckler's veto flips the Constitution on its head. *See M'Culloch* v. *Maryland*, 17 U.S. 316, 330 (1819) (rejecting suggestion "that congress can only exercise its constitutional powers, subject to the controlling discretion, and under the sufferance, of the state governments"). And it has the potential to wreak havoc on hospitals and their patients. If Congress determines that hospitals are being undercompensated for treating a category of Medicaid patients, or that certain recipients need additional services, it must have the prerogative to revise the

program accordingly. Patients have nowhere else to turn for treatment, and providers have nowhere else to turn for payment.

These practical concerns underscore the legal flaws that doom Petitioners' case. Their coercion arguments should be rejected, and the ACA's Medicaid provisions sustained, for three primary reasons:

1. The "coercion doctrine," always more a whisper than a doctrine, is unworkable. It also has been overtaken by events: The anti-commandeering principle, developed by this Court in the years since it last mentioned "coercion," does the necessary work to safeguard federalism. The Court should abandon any separate coercion inquiry, recognizing, as it has in other contexts, that there is a distinction of constitutional magnitude between encouragement—no matter how persuasive—and direct legislative command.

2. If the Court were to decide there is a coercion doctrine, it should limit the doctrine's application to cases where Congress attempts to regulate activities outside "the scope of national policy and power." *Steward Mach. Co.* v. *Davis*, 301 U.S. 548, 590 (1937). After all, this Court was motivated to suggest a coercion theory in the first place by the concern that Congress might use the Spending Power to usurp the states' police powers, eliminating the line between federal and state authority. That concern has no resonance in cases, like this one, where Congress regulates within a longtime federal sphere. In such cases, the only concern should be to ensure that Congress is not commandeering the states "by directly compelling them to enact and enforce a federal regulatory program." *New York* v. *United*

States, 505 U.S. 144, 161 (1992) (citation omitted). The ACA's Medicaid provisions do not constitute commandeering. They should be sustained.

3. Finally, even if the Court decided to recognize a coercion doctrine, and even if it applied in this case, the Court still should affirm the holding below. The ACA's Medicaid provisions are not impermissibly coercive. States remain free to decline the federal government's Medicaid payments. And while Petitioners assert the contrary, that assertion is belied by the fact that legislators from some of the Petitioner states have recently, and publicly, considered dropping out of the Medicaid program. *See, e.g.*, D. Montgomery, *Push to Opt Out of Medicaid Alarms Texas Health Providers*, Fort Worth Star-Telegram (Nov. 14, 2010).[3] The Petitioner states may face difficult *political* decisions about whether and how to participate in Medicaid, but they cannot show actual "coercion." The decision below regarding Medicaid should be affirmed.

ARGUMENT

I. THIS COURT SHOULD REJECT PETITIONERS' COERCION THEORY.

A. The Coercion Theory Is Both Unworkable And Unnecessary.

1. The Court has said very little about the "coercion doctrine"; indeed, it has only suggested—and it never has held—that the doctrine exists at all. *See Steward Mach.*, 301 U.S. at 590 ("Nothing in the case suggests the exertion of a power akin to undue influence, if we *assume* that such a concept can ever

[3] *Available at* http://www.mcclatchydc.com/2010/11/14/103709/texas-push-to-opt-out-of-medicaid.html.

be applied with fitness to the relations between state and nation.") (emphasis added); *South Dakota* v. *Dole*, 483 U.S. 203, 211 (1987) ("Our decisions have recognized that in some circumstances the financial inducement offered by Congress *might* be so coercive as to pass the point at which 'pressure turns into compulsion.' ") (citation omitted; emphasis added).

It should now abandon the theory altogether. The notion that judges can determine in some principled way the point at which "pressure" applied to a state "turns into compulsion," *Dole*, 483 U.S. at 211, was doomed from the start. How can a judge possibly decide, as an empirical matter, whether a state is truly "coerced" in the sense that it has no choice but to accept federal funds? How large must the federal program be, and what percentage of the state's budget must it provide? And even if a judge could determine that a particular state is "coerced," how many states must fall into that category before the congressional program is invalidated? What if 49 states could refuse the federal funds without difficulty but one, faced with idiosyncratic budget pressures, could not? There is no way to draw principled lines. These are not the sorts of metrics that make for a coherent constitutional rule.

The Courts of Appeals have recognized as much. The D.C. Circuit, for example, questioned its competency to determine "whether the states are faced * * * with an offer they cannot refuse or merely a hard choice." *Oklahoma* v. *Schweiker*, 655 F.2d 401, 414 (D.C. Cir. 1981). And the Ninth Circuit recognized the "[t]he difficulty if not the impropriety of making judicial judgments regarding a state's financial capabilities." *Nevada* v. *Skinner*, 884 F.2d 445,

448 (9th Cir. 1989). Just so. To ask whether "there is any form or level of inducement that can truly render someone unable to choose"—not to mention "what choice and compulsion mean when we are talking about *states* rather than persons"—is to delve into a "deep[ ] philosophical question." L. Tribe, *American Constitutional Law* 841 (3d ed. 2000). Federal courts are not well-suited to adjudicate philosophical questions. Indeed, the impossibility of the task is underscored by this very case: Petitioners insist that the ACA's expansion of Medicaid is the most extreme example of coercion that will ever arise, Pet. 21, and yet even on these supposedly extreme facts the states are not truly "coerced." *See infra* at 15-23.[4]

2. Moreover, the notion that underlies the coercion theory—that governmental encouragement has the same constitutional effect as a direct command if only the facts are sufficiently extreme—contradicts this Court's teachings in other areas. In contexts as diverse as criminal law and the First Amendment, the Court has recognized that encouragement, no matter how forceful, is *not* the same as a command. *See*, *e.g.*, *Christian Legal Soc'y* v. *Martinez*, 130 S. Ct. 2971, 2986 (2010) ("[O]ur decisions have distin-

[4] Notably, the states themselves historically have failed to agree about whether the "coercion" theory is workable. In *Dole*, the National Conference of State Legislatures and the National Governors' Association, among others, filed an amicus brief warning of "the difficulties inherent in determining 'the location of the point at which pressure turns into compulsion' " and arguing against adoption of a "coercion" test. Amicus Br. of the Nat'l Conference of State Legislatures et al., 1987 WL 880310, at *16-*17 (Jan. 22, 1987) (citation omitted). And many states and state officials disagree with the Petitioners in the current case and have argued in favor of affirmance on the Medicaid issue. *See infra* at 17.

guished between policies that require action and those that withhold benefits") (collecting cases).[5] To conflate the two—to try and identify that point where "encouragement" becomes an *implicit* "command"—is to venture too far into the philosophical thicket. Every offer of money "is in some measure a temptation," but "to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties." *Steward Mach.*, 301 U.S. at 589-590.

3. Rejecting the coercion theory would not leave states unprotected. That is so because the "anti-commandeering" principle this Court established in *New York* v. *United States* ensures that the federal government cannot directly command the states to implement regulatory programs. That principle protects the states against federal encroachment. It properly distinguishes encouragement from compulsion. And its bright-line test avoids the insoluble problems of the coercion theory. This Court should hold that the anti-commandeering doctrine has supplanted any attempt to identify "coercion" in Congress' interactions with the states.

In *New York*, the Court held that Congress cannot " 'commandeer' state governments into the service of federal regulatory purposes." 505 U.S. at 175. That is to say, Congress cannot directly command the states to regulate in a certain way. Petitioners argue

[5] This distinction lends no support to arguments against the ACA's minimum-coverage provision. Petitioners' objection to the minimum-coverage provision is that it impermissibly bootstraps the Commerce power by compelling purportedly "inactive" individuals to enter commerce. That is a constitutionally distinct argument. And it fails for the reasons stated by the federal government in the minimum-coverage proceeding.

that the ACA's Medicaid provisions effectively amount to commandeering because they are so coercive as to take away the states' choice. *See* Pet. Br. 25. But that argument distorts the holding of *New York*. The *New York* Court explained that state sovereignty is offended by direct commands from the federal government because the state's citizens no longer "retain the ultimate decision as to whether or not the State will comply." 505 U.S. at 168. Yet where Congress "*encourages* state regulation rather than compelling it, state governments remain responsible to the local electorate's preferences[.]" *Id.* (emphasis added). That distinction is in line with *Martinez*. Moreover, *New York* never mentioned coercion—in the sense of an offer being too good to refuse—as a free-standing check on the Spending power. Instead, it referred to "four respects" in which a congressional grant might contravene the Spending Clause, none of which was coercion. *Id.* at 171-172.

In the wake of *New York*, commentators suggested that the "anti-commandeering" test had supplanted *Dole*'s "coercion" theory: So long as the federal government does not command states to carry out federal policies, the states are not constitutionally coerced. *See* K. Sayers-Fay, *Conditional Federal Spending*: *A Back Door to Enhanced Free Exercise Protection*, 88 Cal. L. Rev. 1281, 1299-1300 (2000); C.R. McConville, *Federal Funding Conditions: Bursting Through the* Dole *Loopholes*, 4 Chap. L. Rev. 163, 175-177 (2001). This Court should embrace that reading of *New York*. It aligns the Spending Clause jurisprudence with other areas of the law. It requires no deep dive into states' financial ledgers. And it avoids the "endless difficulties," *Steward*

Mach., 301 U.S. at 590, of drawing the elusive line between encouragement and compulsion.

Applying this sensible reading, the Court should affirm the decision below. The anti-commandeering rule prohibits only direct federal commands compelling state action. *See New York*, 505 U.S. at 161 (Congress may not " 'commandee[r] the legislative process of the States by *directly compelling* them to enact and enforce a federal regulatory program.' ") (quoting *Hodel* v. *Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 288 (1981)) (emphasis added); *Printz* v. *United States*, 521 U.S. 898, 933 (1997). The ACA's Medicaid provisions do not meet that description. Encouragement, however forceful, is just that. The Medicaid statute encourages—some may say strongly encourages—state participation. But it does not commandeer the states. The Eleventh Circuit's ruling on the Medicaid issue should be affirmed.

B. If The Coercion Theory Is Viable, It Should Be Limited To Cases Where Congress Tries To Invade The States' Police Power.

1. Even if the coercion theory were viable, it should be limited in application to the category of cases that gave rise to it in the first place—those in which Congress attempts to intrude on the States' police power.

On the rare occasions when the Court has mentioned the coercion theory, it has always framed its concern as one about congressional attempts to usurp the reserved authority of the States. In *United States* v. *Butler*, 297 U.S. 1 (1936), for example, the Court wrote that the Framers' writings "will be searched in vain for any suggestion" that the Spend-

ing Clause contains "authority whereby * * * the independence of the individual states [may be] obliterated, and the United States converted into a central government exercising uncontrolled police power in every state of the Union, superseding all local control or regulation of the affairs or concerns of the states." *Id.* at 77. And in *Steward Machine*, the Court expressed concern about Congress attempting to "intrude upon fields foreign to its function." 301 U.S. at 590; *see also United States* v. *Comstock*, 130 S. Ct. 1949, 1964 (2010) (expressing desire to avoid "confer[ring] on Congress a general police power, which the Founders denied the National Government and reposed in the States") (citation omitted).

If the coercion theory has any resonance at all, it is in cases presenting this concern. One could imagine a situation where Congress attempted to intrude on the States' traditional local police powers by, for example, threatening to withhold all federal funding unless the States agree to change their zoning laws, or to eliminate no-fault divorce. While the States would retain the political capacity to reject Congress' pressure, *see supra* at 7-8, more searching judicial oversight nonetheless might be appropriate to safeguard the States' prerogative to "remain independent and autonomous within their proper sphere of authority." *Printz*, 521 U.S. at 928.

But that concern has no application where Congress is regulating "activities fairly within the scope of national policy and power." *Steward Mach.*, 301 U.S. at 590. In such circumstances, Congress by definition does not "intrude upon fields foreign to its function," *id.*, or "exercis[e] uncontrolled police power," *Butler*, 297 U.S. at 77. Federalism is not at risk. There accordingly is no reason in such cases to

involve the courts in the tricky exercise of discerning "the point at which pressure turns into compulsion." *Dole*, 483 U.S. at 211. Instead, the courts should employ the bright-line check provided by the anti-commandeering doctrine. *See supra* at 9-11.

2. To be sure, the Court has never articulated this limit on the coercion theory. But the limit is suggested by a comparison between *Dole* and *New York*. In *Dole*, the Court was faced with a congressional attempt to intrude on an area—control over the drinking age—that falls within the state's traditional police power. *See* 483 U.S. at 206, 211-212. Because Congress' attempt to pressure South Dakota to adopt a 21-year-old drinking age risked intruding on the state's traditional prerogatives, the Court raised the issue of coercion; it considered (but did not decide) whether the incentive offered was so coercive as to be impermissible. *See id.* at 211.

In *New York*, by contrast, the regulatory issue—treatment and disposal of low-level radioactive waste—was indisputably a matter of federal concern; as the Court explained, "Congress has substantial power under the Constitution to encourage the States to provide for the disposal of the radioactive waste generated within their borders." 505 U.S. at 149. There accordingly was no concern that congressional Spending Clause regulation would interfere with traditional state prerogatives. And in that setting, the Court said nothing about coercion. It focused instead on the risk that Congress would directly commandeer state legislative processes, rendering state officials unaccountable to their constituents. *See id.* at 169.

3. Deciding whether Congress is using its Spending Clause prerogatives to encourage "activities fairly within the scope of national policy and power," *Steward Mach.*, 301 U.S. at 590, would, of course, require judicial line-drawing. But the inquiry would not be unprecedented. The Court has recognized in other settings that the federal government's historical role in a field is relevant to determining the balance of power between national and state governments. In the preemption context, for example, the Court has suggested that the presumption against preemption is inapplicable "when the State regulates in an area where there has been a significant history of federal presence." *United States* v. *Locke*, 529 U.S. 89, 108 (2000). If that inquiry is administrable in the preemption context, it is administrable here too.

4. Applying these principles—and, again, assuming the coercion theory is recognized at all—the Court should eschew the theory here. Medicaid provides payment for health care services through a long-existing federal program that, in many ways, serves as a public analogue of health insurance. Moreover, federal involvement in providing and regulating health care and insurance long predates Medicaid. More than 200 years ago, Congress enacted an "Act for the relief of sick and disabled seamen" that was the genesis for the National Public Health Service. J. Parascandola, Public Health Service Commissioned Officers Foundation, *History*.[6] This Court later described the problem of caring for the unemployed and elderly—a problem comparable to the one addressed by Medicaid—as "plainly national in area

[6] *Available at* http://www.coausphs.org/docs/history.pdf.

and dimensions." *Helvering* v. *Davis*, 301 U.S. 619, 643-644 (1937). Congress likewise has long had a presence in the health care field by virtue of the Medicare program. And it is settled that insurance is a matter of federal concern: While Congress made the affirmative decision to leave much insurance regulation in the states' hands, *see* 11 U.S.C. § 1012 (McCarran-Ferguson Act), it has Commerce Clause authority to regulate insurance and has done so in many instances, including through the ACA itself. *See United States* v. *South-Eastern Underwriters Ass'n*, 322 U.S. 533, 551-553 (1944) (insurance regulation is within the Commerce power).

The ACA's Medicaid provisions, in short, address "activities fairly within the scope of national policy and power," not "fields foreign to [Congress'] function." *Steward Mach.*, 301 U.S. at 590. The only question for the Court accordingly should be whether the provisions commandeer the States. They do not, for the reasons already discussed. The decision below should be affirmed against petitioners' Medicaid challenge.

II. EVEN IF THE COERCION THEORY APPLIED HERE, IT WOULD NOT INVALIDATE THE ACA'S MEDICAID PROVISIONS.

Finally, even if the coercion theory were recognized, and even if it applied in these circumstances, the ACA's Medicaid provisions would survive review. Petitioners argue that they cannot extricate themselves from Medicaid. That assertion does not withstand scrutiny—not least because some of these very Petitioners have announced they are considering the very step they claim is impossible.

To be sure, exiting Medicaid would be politically difficult, and it could be expensive. But that mere hard choice cannot amount to unconstitutional coercion. If it did, the states could freeze a federal program, and block Congress from improving it in any significant way, so long as *one* participating state decides to wave a red flag. Medicaid recipients and health care providers—the two constituencies that interact with and rely on Medicaid the most—would be unable to count on Congress to make the adjustments needed to keep the program working effectively. That is not a sensible rule of law.

1. Petitioners suggest throughout their brief that it is impossible for them to withdraw from Medicaid, and that accordingly the situation here amounts to commandeering by another name. *E.g.*, Pet. Br. 26. But they cannot quite bring themselves to say it outright. Instead, they hedge: They assert that a state's "*practical ability* to ask residents" to exit Medicaid and pay for a state health insurance program "*is all but nil*," Pet. Br. 43 (emphases added), and they claim that "Florida has no *practical ability to inform its citizens*" that it will be declining federal monies and raising state taxes to offset the loss. Pet. Br. 44 (emphasis added).

There is a reason for this cautious phrasing: Any claim that it is impossible to exit Medicaid would not withstand scrutiny. For starters, the words of Petitioners' own state legislators would cast doubt on the assertion. Lawmakers in Texas—one of the Petitioner states—recently pondered the very move that Petitioners now suggest is impossible: dropping out of the Medicaid program. *See* Montgomery, *supra*. "The opt-out plan * * * quickly emerged as another high-profile topic for the 2011 Legislature," champi-

oned by "a number of conservative lawmakers who believe that Texas can provide health coverage to the indigent more efficiently with a state-run plan free of federal mandates." *Id.* And as recently as last winter—at a time when this litigation was already in full swing—a legislator in Florida threatened that state's withdrawal from Medicaid, stating that "[i]f the federal government elects not to allow us to manage the program the way we believe is in Florida's best interests, then we'll operate our Medicaid program with our resources." B. Larrabee, *Florida Might Try to Withdraw From Medicaid*, Florida Times-Union, Feb. 16, 2011.[7]

Those statements undercut the Petitioners' primary factual contention. And they are hardly outliers. As the Solicitor General points out, many states and state legislators have filed briefs in support of the PPACA's Medicaid amendments in this case, telling the Court both that the amendments are good for states and that states could withdraw from the Medicaid program if necessary. *See* Govt' Br. 34-35. Indeed, in the proceeding below, legislators from 26 states—*including 15 of the Petitioner states*—disputed the Petitioners' coercion claims and acknowledged that "States could opt out of [Medicaid] if their leaders and citizens so desired, avoiding the Act's new requirements for expanded Medicaid coverage." Amicus Br. of State Legislators, 2011 WL 1461595, at *1, *27 (Apr. 7, 2011).

Nor would Texas and Florida be the first states to make do without Medicaid. Arizona, another of the Petitioners in this proceeding, did not offer any sort

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[7] *Available at* http://jacksonville.com/news/florida/2011-02-16/story/florida-might-try-withdraw-medicaid.

of Medicaid program until 1982—17 years after the program began—and even today it is not a full participant in the usual sense. The state now offers "an alternative to traditional Medicaid," called the Arizona Health Care Cost Containment System, as a demonstration project approved by the federal government. N. McCall, *Lessons from Arizona's Medicaid Managed Care Program*, Health Affairs, July-Aug. 1997, at 194.[8]

These data points show that it is not impossible for a state to remain separate from or exit Medicaid. And indeed, a number of courts have rejected the precise argument Petitioners make here: that "while [a state's] choice to participate in Medicaid may have been voluntary, it now has no choice but to remain in the program in order to prevent a collapse of its medical system." *California* v. *United States*, 104 F.3d 1086, 1092 (9th Cir. 1997); *see also*, *e.g.*, *Schweiker*, 655 F.2d at 414. As the *California* court observed, it is nearly impossible for a court to know whether "a sovereign state[,] which is always free to increase its tax revenues," is actually being "coerced by the withholding of federal funds." 104 F.3d at 1092 (citation omitted). It refused to find coercion on the record of that case. *Id.* Nothing of substance has changed in the intervening years.

2. Petitioners contend that this case *is* different because the ACA "revolutionizes" Medicaid in a way past modifications did not. Pet. Br. 34. That overstates the case. The ACA's Medicaid provisions are part of a long line of measures expanding the scope of the program and the requirements it imposes on

[8] *Available at* http://content.healthaffairs.org/cgi/reprint/16/4/194.pdf.

participants. For example, 1972 amendments "[r]equired states to extend Medicaid to [Supplemental Security Income] recipients or to elderly and disabled" people meeting certain criteria. Kaiser Comm'n on Medicaid & The Uninsured, *The Medicaid Resource Book* 175 (App'x 1) (2002) ("*Medicaid Resource Book*").[9] A 1984 amendment "[r]equired states to cover children born after September 30, 1983, up to age 5, in families meeting state [welfare] income and resource standards." *Id.* And since 1991, states have been "required to cover all children over the age of five and under 19 who are in families with income below 100% of the federal poverty level." Congressional Res. Serv., *How Medicaid Works: Program Basics* 4 (2005).[10] With respect to the income criteria, amendments enacted between 1986 and 1991 "require [states] to cover pregnant women and children under age 6 with family incomes below 133% of the federal poverty income guidelines." *Id.* at 3-4. And a 1990 amendment "[r]equired states to phase in coverage of Medicare premiums for low-income Medicare beneficiaries with incomes between 100 and 120 percent of poverty." *Medicaid Resource Book* 176.

The current expansions to the Medicaid program are no different in kind from what came before. And states throughout have remained (and continue to remain) free to withdraw from the Medicaid program. As this Court itself has recognized, "participation in the program is voluntary[.]" *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

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[9] *Available at* http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14255.

[10] *Available at* http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL3227703162005.pdf.

3. Petitioners separately argue that their citizens' federal tax burden somehow renders the ACA Medicaid provisions coercive. They assert that it would be all but impossible "to ask residents, already taxed by the federal government to provide health insurance elsewhere, to contribute additional taxes to supplant the declined federal program," and they compare the federal government to a "pickpocket who takes a wallet and gives the true owner the 'option' of agreeing to certain conditions to get the wallet back or having it given to a stranger." Pet. Br. 43-44.

This argument is far off the mark. Unlike the victim in Petitioners' colorful analogy, state residents do not actually have any "owner[ship]" rights or expectations in federal tax dollars. *Id.* In 2003-04, for instance, New Jersey received 55 cents in federal spending for every dollar its residents paid in federal taxes. C. Dubay, Tax Foundation, *Federal Tax Burdens and Expenditures by State: Which States Gain Most from Federal Fiscal Operations?* 2 (March 2006).[11] During that same period, Mississippi received $1.77 in federal spending for every federal tax dollar contributed by its residents. *Id.* For better or worse, state residents cannot reasonably expect to receive a perfect quid pro quo for their federal tax dollars. And it is, at best, doubtful whether a state's limited "return" on its residents' federal tax contributions in any way constrains that state's ability to impose new taxes. By way of example, in spite of the fact that historically it has received in federal spending only a fraction of the federal tax dollars contributed by its residents, *id.*, New Jersey boasts one of the highest state and local tax burdens in the nation.

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[11] *Available at* http://www.taxfoundation.org/files/sr139.pdf.

Tax Foundation, *2011 Facts & Figures: How Does Your State Compare?* at Tbl. 2 (2001).[12]

In any event, it is far from clear that withdrawing from Medicaid would require the states to raise taxes. The Heritage Foundation came to just the opposite conclusion in a recent study, finding that "about 40 states would save money overall by opting out of Medicaid, even if they continued to provide some services, and despite the loss of federal support." M. DoBias, *What if States Drop Medicaid?*, Nat'l J. (Nov. 18, 2010).[13] Whatever the validity of that estimate, it apparently spurred some Petitioner states to consider exiting Medicaid in the first place. *See id.* And that fact further undercuts Petitioners' theory of the case: In the real world, at least some of the Petitioners are unsure whether exiting Medicaid would even be a fiscal hardship—much less a fiscal impossibility.

4. The states' argument, in the end, is merely that it would be difficult to defend a Medicaid withdrawal to their citizens. But "[h]ard choices do not alone amount to coercion." *Van Wyhe* v. *Reisch*, 581 F.3d 639, 652 (8th Cir. 2009) (citation omitted). This Court said exactly that in *New York*: "If a State's citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant." 505 U.S. at 168. By contrast, "[i]f state residents would prefer their government to devote its attention and resources to problems other than those deemed important by Congress, they may choose to have the Federal Government rather than the State

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[12] *Available at* http://www.taxfoundation.org/files/ff2011.pdf.

[13] *Available at* http://www.nationaljournal.com/member/magazine/what-if-states-drop-medicaid--20101118.

bear the expense of a federally mandated regulatory program[.]" *Id.*

State legislators are charged with determining the will of their constituents on these matters. If they misjudge, they should be held accountable in the next election. That is the very essence of republican government. Whatever its proper scope (if any), the coercion theory cannot be used to shield legislators from their responsibilities in the system.

5. Finally, as we mentioned at the outset, it is critical to understand the practical consequences of the argument Petitioners advance: If their theory were law, *all* of the important modifications Congress has made to Medicaid over the decades—modifications that were necessary to respond to demographic developments, innovations in the medical delivery system, and other changes on the ground—could have been blocked by a lone participant state. Or, perhaps more likely, states would have blocked the changes that increased their costs and allowed others to stand. *Cf.* Pet. Br. 49 ("[W]hen no State even 'suggest[s]' spending legislation is coercive, * * * that is certainly a strong indication that States' acceptance of federal conditions was voluntary[.]") (citation omitted).

Moreover, under Petitioners' theory, states could wield their heckler's veto to block any adjustment Congress might make to Medicaid in the future—not just significant amendments, but adjustments as routine and minor as new quality measures or reporting requirements. After all, Petitioners contend that it is the size of the grant the state stands to lose, not the activity the federal government asks states to undertake, that provides the measure of coercion.

Pet. Br. 46. If that is so, every Medicaid amendment is just as "coercive" as the ones at issue here. Congress would be able to make even non-substantive changes to the program only at the states' pleasure.

This Court should reject that approach. It is legally unsound. And it also is treacherous for those who rely on cooperative federal-state programs and on Congress' ability to keep those programs running smoothly and fairly. Congress' best judgment on these matters cannot be held hostage at the whim of some objecting states.

CONCLUSION

For all of the foregoing reasons, this Court should uphold the Medicaid provisions of the ACA.

Respectfully submitted,

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